BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
DAVID HWAN KIM, M.D.	)	Case No. 800-2015-017032
Physician's and Surgeon's Certificate No. A87499	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 16, 2018.

IT IS SO ORDERED: October 17, 2018.

MEDICAL BOARD OF CALIFORNIA

Ronald Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
MARGARET J. PHE
Deputy Attorney General
State Bar No. 207205
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6443
Facsimile: (213) 897-9395
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DAVID HWAN KIM, M.D. 4448 E. Village Road Long Beach, CA 90808 Physician's and Surgeon's Certificate No. A 87499 Respondent.	Case No. 800-2015-017032 OAH No. 2018050386 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Margaret J. Phe, Deputy Attorney General.

2. Respondent David Hwan Kim, M.D. (Respondent) is represented in this proceeding by attorneys William C. Haggerty, whose address is: One World Trade Center, 27th Floor Long Beach, CA 90831, and Norman L. Schafler, Esq., whose address is: P.O. Box 7073

Halcyon, CA 93421

3. On or about June 4, 2004, the Board issued Physician's and Surgeon's Certificate No. A 87499 to David Hwan Kim, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-017032, and will expire on October 31, 2019, unless renewed.

JURISDICTION

4. Accusation No. 800-2015-017032 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 14, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2015-017032 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-017032. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2015-017032, if proven at a hearing, constitute cause for imposing discipline upon his

Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communication from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Board, in its discretion, does not approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of

this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should the Board reject this Stipulated Settlement and Disciplinary Order for any reason, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 87499 issued to Respondent David Hwan Kim, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65

hours of CME of which 40 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s)

and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a

replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

4. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and

Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

11. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

12. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the

Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, William C. Haggerty and Norman L. Schafler, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 9/7/18

DAVID HWAN KIM, M.D.
Respondent

I have read and fully discussed with Respondent DAVID HWAN KIM, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/7/18

WILLIAM C. HAGGERTY
Attorneys for Respondent

DATED: _____

NORMAN L. SCHAFLER, ESQ.
Attorneys for Respondent

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, William C. Haggerty and Norman L. Schafler, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 9/7/18

DAVID HWAN KIM, M.D.
Respondent

I have read and fully discussed with Respondent DAVID HWAN KIM, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/7/18

WILLIAM C. HAGGERTY
Attorneys for Respondent

DATED: 9/7/18

NORMAN L. SCHAFLER, ESQ.
Attorneys for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 9/7/18

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

Margaret J. Phe

MARGARET J. PHE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-017032

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
MARGARET J. PHE
Deputy Attorney General
State Bar No. 207205
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6443
Facsimile: (213) 897-9395
E-mail: margaret.phe@doj.ca.gov
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **David Hwan Kim, M.D.** 4448 East Village Road Long Beach, CA 90808 Physician's and Surgeon's Certificate No. A 87499, Respondent.	Case No. 800-2015-017032 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 4, 2004, the Board issued Physician's and Surgeon's Certificate Number A 87499 to David Hwan Kim, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following

laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2229 of the Code states:

"(a) Protection of the public shall be the highest priority for the Division of Medical Quality,[1] the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

"(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.

[1] Pursuant to Business and Professions Code section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

"(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount."

7. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

". . ."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain

adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Facts

9. On or about April 23, 2008, the Dental Board of California (DBC) issued General Anesthesia Permit Number 1443 to Respondent.

10. On or about January 13, 2016, the DBC issued Oral Maxillofacial Surgery Permit Number 63 to Respondent.

11. Patient A[2] was referred to Respondent by her regular dentist for a consultation regarding extraction of root tips on three (3) teeth under general anesthesia in preparation for future implants.

12. On or about April 15, 2014, patient A went to Respondent's office for a pre-surgical consultation, as reflected in Respondent's progress notes. Respondent examined patient A and took a history. Respondent's progress notes for this visit are mostly illegible.

13. Patient A was a 56-year-old female, 6 feet tall, who weighed 245 pounds, with a BMI[3] of 33. The patient had a history of hypertension, lower extremity edema, greater than one pillow orthopnea.[4] The patient's medical records from her previous oral surgeon's March 22, 2009 physical assessment of her airway stated, "[the patient] has a deficient mandible and opening limited to 1.5 finger breadths [sic]."

14. Patient A filled out Respondent's medical history form. Patient A's response to the form's question regarding unfavorable reactions during surgery or dental treatment was, "Unable to intubate – cleft palate repair."

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[2] The name of the patient and any witnesses are abbreviated to protect privacy rights. The names will be provided to Respondent upon written request for discovery.

[3] BMI is defined as a person's weight in kilograms (kg) divided by their height in meters (m) squared. BMI stands for body mass index. BMI is often used as a screening tool to decide a person's weight might be a risk factor for health problems such as heart disease.

[4] Orthopnea is difficulty in breathing that occurs when lying down and is relieved upon changing to an upright position. The severity of this symptom usually depends on how flat the person is lying - the shortness of breath is more severe the flatter the person lies. To gauge the severity of this symptom, doctors often ask people how many pillows they need to lie on to avoid feeling short of breath in bed. A person with "three-pillow" orthopnea is worse than "two-pillow" orthopnea, because the person has less tolerance for lying flat.

15. Patient A's response to the form's question regarding "Do you have any information you think I should know about?" was, "Do not open my mouth wide."

16. In many of her medical records Patient A emphasized her medical alert: "Unable to intubate – restrictive jaw opening." When she filled out the Respondent's form regarding her preoperative medical history, Patient A also stated, "Unable to intubate – restrictive jaw opening."

17. Respondent assigned the patient an American Society of Anesthesiologists (ASA) risk classification status[5] of ASA 2.

18. Patient A's pre-operative history listed the following medications: Methyldopa,[6] Atenolol,[7] Lisinopril,[8] Furosemide,[9] and Lovastatin.[10]

19. Respondent's records do not indicate Respondent encouraged patient A to utilize local instead of general anesthesia for her procedure.

20. On May 2, 2014, patient A presented to Respondent's office for her surgery and signed consents for oral surgery, grafting, and anesthesia. Respondent's preoperative intake form states patient A was nervous, obese, had a thick neck, receded chin, and contains an illegible notation regarding the patient's palms.

21. Many of the questions on Respondent's preoperative intake form were blank. The intake form does not indicate an evaluation of the patient's cardiac, pulmonary status or temperature. The patient's initial vital signs were blood pressure 139/86, pulse 66, and

[5] ASA physical status classification system is a system for assessing the fitness of patients before anesthesia. In 1963 the American Society of Anesthesiologists adopted the five-category physical status classification system; a sixth category was later added. These include: (1) Healthy person; (2) Mild systemic disease; (3) Severe systemic disease; (4) Severe systemic disease that is a constant threat to life; (5) A moribund person who is not expected to survive without the operation; (6) A declared brain-dead person whose organs are being removed for donor purposes.

[6] Methyldopa is a medication used for high blood pressure. Methyldopa works by stimulating the brain to decrease the activity of the sympathetic nervous system.

[7] Atenolol is a beta-blocker that affects the heart and is used to treat angina and hypertension.

[8] Lisinopril is an ACE inhibitor (ACE stands for angiotensin converting enzyme) used to treat hypertension.

[9] Furosemide is a medication used to treat fluid build-up used for the treatment of hypertension.

[10] Lovastatin is a statin drug used for lowering cholesterol to reduce risk of cardiovascular disease.

respiration 20.

22. Respondent's intraoperative anesthetic chart does not contain a time-based anesthesia record for the patient. Respondent's automatic vital signs monitor records reflect time recordings, which are approximately one hour earlier than the correct time clock as the monitor was set one hour earlier than the correct clock time.

23. The Anesthesia Start written on the chart was 12:50 p.m. There is no time of induction and no medication listed for induction, maintenance, or medication during surgery.

24. The intraoperative anesthetic chart is largely blank with no procedural vital signs, times, or route given for the medication.

25. Off to the side of the intraoperative anesthetic chart there is the following handwritten notes: "2 oxy & Hal 1 :40 AD and R forearm." Further down on the chart, it appears that Propofol was given at an unreadable dose at an unknown time, and Oxygen was given at an unknown rate.

26. Respondent's intraoperative anesthetic chart does not contain any record of any antibiotics given to the patient.

27. Respondent's intraoperative anesthetic chart does not contain any record of an electrocardiogram being used during the patient's surgery.

28. Respondent's intraoperative anesthetic chart does not contain any record of how much oxygen was administered to the patient during the patient's surgery.

29. Respondent's intraoperative anesthetic chart does not contain any record of how the patient's $CO2$[11] was monitored throughout the surgery.

30. Respondent's intraoperative anesthetic chart does not contain a record of any documentation of the type, volume, or amount of time any intravenous fluid may have been given to the patient.

[11] CO2 is carbon dioxide in a person's respiratory gases. During anesthesia, there is interplay between two components: the patient and the anesthesia administration device. The critical connection between the two components is either an endotracheal tube or a mask, and CO2 is typically monitored at this junction. Sudden changes in CO2 elimination during surgery usually imply important changes in the patient's cardiorespiratory function.

31. On an unmarked, undated piece of paper separate from the anesthesia chart is a handwritten note of medications: "Premed Oral 1:40 pm - Oxycodone[12] SR 10 mg x 2, Triazolam[13] .25 mg x 1, Induction 1:50-midazolam[14] 2mg IV, Propofol[15] 50 mg IV, Decadron[16] 6 mg IV, Atropine .4 mg IV Maintenance (unknown time) - Propofol 50 mg IV, Ketamine[17] 50 mg IV, Reversal (unknown time) - .1 mg Flumazenil[18] IV, Local anesthetic (unknown time) 2% Lidocaine[19] with epi, .5% Bupivicaine[20] with epi."

32. After the induction Respondent's records appear to indicate patient A began to have respiratory issues with desaturations and poor ventilation evidenced by intermittent CO2.[21] Respondent changed the patient's oxygen delivery to nasal positive pressure ventilation, and nasal airways. Respondent administered additional anesthetic medication.

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[12] Oxycodone is an opioid pain medication.

[13] Triazolam (original brand name Halcion) is a central nervous system (CNS) depressant in the benzodiazepine class. It possesses pharmacological properties similar to those of other benzodiazepines, but it is generally only used as a sedative to treat severe insomnia.

[14] Midazolam, marketed under the trade name Versed, among others, is a medication used for anesthesia, procedural sedation, trouble sleeping, and severe agitation.

[15] Propofol: a prescription sedative-hypnotic drug administered intravenously. Propofol is commonly used in the induction of general anesthesia and can be used both for the induction and maintenance of general anesthesia.

[16] Decadron is a corticosteroid. It is commonly used to treat inflammation of the skin, joints, lungs, and other organs. Common conditions treated include asthma, allergies, and arthritis.

[17] Ketamine is a nonbarbiturate anesthetic related to phencyclidine, administered intravenously or intramuscularly to produce dissociative anesthesia.

[18] Flumazenil is used as an antidote in the treatment of benzodiazepine overdoses.

[19] Lidocaine is an anesthetic with sedative, analgesic, and cardiac depressant properties, applied topically in the form of the base or hydrochloride salt as a local anesthetic; it is also used in the latter form to treat cardiac arrhythmias and to produce infiltration anesthesia and various nerve blocks.

[20] Bupivicaine is a medication used to decrease feeling in a specific area. It is used by injecting it into the area, around a nerve that supplies the area, or into the spinal canal's epidural space.

[21] Carbon dioxide is a colorless, odorless gas produced by the oxidation of carbon; also a "greenhouse" gas. Carbon dioxide, as a product of cell respiration, is carried by the blood to the lungs and is exhaled. The acid-base balance of body fluids and tissues is affected by the level of carbon dioxide and its carbonate compounds. Normal adult blood levels of carbon dioxide are 23 to 30 mEq/L or 23 to 30 mmol/L (SI units).

33. Respondent's records appear to indicate he administered 0.1 mg of Flumazenil[22] to attempt to reverse the combined effects of the Versed[23] and Halcion[24] he previously administered to the patient.

34. Respondent did not attempt to awaken patient A and place a noninvasive rescue supraglottic airway[25]at any time.

35. Respondent's records contain an electronic printout with initial vital signs at 12:54 p.m. with a heart rate of 9_, Spo2[26] of 9_, RR[27] 23 and BP[28] of 199/119. Respondent's records appear to indicate patient A was very hypertensive[29] and after 5 minutes desaturated[30] for at least 7 minutes. Respondent's records indicate patient A experienced a brief period of slight

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[22] Flumazenil is a prescription medication used to manage an overdose of a certain class of sedative medications called benzodiazepines. It is also used following a medical procedure where benzodiazepines have been used. Flumazenil belongs to a group of drugs called antidotes. These help to reverse the effects of an overdose of benzodiazepines.

[23] Versed is a medication used for anesthesia, procedural sedation, trouble sleeping, and severe agitation.

[24] Halcion is a benzodiazepine medicine used to treat insomnia and sometimes to reduce anxiety before dental work.

[25] Noninvasive rescue supraglottic airway is one of two categories of airway management. Optimal airway management strategies seek to assist with airway patency, oxygen delivery, and carbon dioxide excretion. Airway management techniques are either noninvasive and invasive. Noninvasive airway management strategies include passive oxygenation, bag-valve.mask ventilation, supraglottic airways, and noninvasive positive-pressure ventilation. Invasive airway management strategies include endotracheal intubation, tracheostomy, transcutaneous needle jet ventilation, and cricothyroidotomy.

[26] Pulse oximetry is a noninvasive method of monitoring a patient's oxygen saturation (SO_2). A sensor device is placed on a thin part of the patient's body, usually a fingertip or earlobe. The device passes two wavelengths of light through the body part to a photodetector. It measures the changing absorbance at each of the wavelengths, allowing it to determine the absorbances due to the pulsing arterial blood alone.

[27] "RR" is respiratory rate and is usually determined by counting the number of times the chest rises or falls per minute. The aim of measuring respiratory rate is to determine whether the respirations are. normal, abnormally fast, abnormally slow, or nonexistent.

[28] "BP" stands for blood pressure, which is the pressure that is exerted by the blood upon the walls of the blood vessels and especially arteries and that varies with the muscular efficiency of the heart, the blood volume and viscosity, the age and health of the individual, and the state of the vascular wall.

[29] Hypertensive is defined as abnormally increased blood pressure.

[30] Oxygen desaturation is a decrease in oxygen concentration in the blood resulting from any condition that affects the exchange of carbon dioxide and oxygen.

hypotension[31] at 1:08 p.m. before becoming very hypertensive again.

36. From 1:08 p.m. to 1:16 p.m. patient A appears to have been ventilated as seen by the CO2 levels, before she experienced more episodes of severe hypoxia.[32]

37. Respondent's barely legible records note the patient's "large swollen tongue with laceration" "episodes of apnea and desaturation" "attempted pos [sic] pressure oxygenation" and "procedure aborted. . . "

38. Respondent did not document whether he believed patient A's possibly life threatening reaction to be a traumatic, anaphylactic or angioedema[33] event.

39. Respondent's intraoperative anesthetic chart does not contain a record of Respondent administering any medication to treat the patient A's life threatening event.

40. According to Respondent's records there was "no attempt at intubation" but it does state a "tracheotomy[34] was attempted after calling 911."

41. Long Beach Fire Department paramedics were dispatched to Respondent's office and transported patient A to a local hospital emergency room. At the emergency room the physician determined that Respondent had incorrectly placed the tracheostomy tube in a false passage and therefore the tracheostomy tube was not providing ventilation to patient A.

42. Patient A remained unconscious and unresponsive after she was transported to the hospital. After approximately three (3) weeks Patient A's family removed her from life support, and she died on May 23, 2014. On or about June 7, 2014, a Los Angeles County Department of

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[31] Hypotension is the opposite of hypertension, and is defined as blood pressure that is below the normal expected for an individual in a given environment. Hypotension can signal an underlying problem, especially when it drops suddenly.

[32] Hypoxia (also anoxia) occurs when the brain isn't getting enough oxygen. The brain depends on the blood to provide it with a constant supply of oxygen. Disruption to any part of the body that plays a role in blood or oxygen supply can lead to hypoxia.

[33] Angioedema is an area of swelling of the lower layer of skin and tissue just under the skin or mucous membranes. The swelling may occur in the face, tongue, larynx, abdomen, or arms and legs. Often it is associated with hives. The onset is typically over minutes to hours.

[34] Tracheotomy is a surgical procedure performed to make an opening in the trachea called a tracheostomy. Performed under general anesthesia, a tracheotomy involves positioning a tube through a tracheostomy, or artificial opening in the throat, in an effort to restore airflow to the lungs.

Coroner's physician performed an autopsy on patient A. The coroner ascribed patient A's cause of death to anoxic encephalopathy,[35] due to or as a consequence of complications of anaphylaxis,[36] clinical probable medication effect(s) and due to, or as a consequence of, status-post endodontic procedure for bone graft to the jaw with infection; displaced tracheostomy tube with subsequent hypoxia, obesity, cardiomegaly, and history of hypertension.

43. The standard of practice regarding the intraoperative anesthesia chart requires the physician to accurately and adequately reflect the patient's care.

44. The standard of practice regarding a patient's intraoperative anesthesia chart requires the patient's chart to contain accurate documentation of the dose, time, and route of medications administered to the patient.

45. The standard of practice regarding a patient's intraoperative anesthesia chart requires the physician to utilize physiologic[37] monitoring. The physiologic monitoring must include accurate, time based documentation of the patient's vital signs, medication and events to construct an accurate explanation of what transpired during a patient's surgical procedure.

46. The standard of practice regarding a patient's intraoperative anesthesia chart requires handwritten records accurately reflect the patient's care.

47. The standard of practice regarding providing anesthesia to a patient with a difficult airway requires the physician to consider the use of fiberoptic intubation.[38]

48. The standard of practice regarding providing anesthesia to a patient with a difficult

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[35] Encephalopathy is a general term that means brain disease, damage, or malfunction. The causes of encephalopathy are numerous and varied; they include infections, anoxia and other causes. Encephalopathy is often considered a complication of a primary problem such as anoxia.

[36] Anaphylaxis is an acute allergic reaction to an antigen.

[37] Physiologic monitoring is defined as continuously measuring and supporting sedated or anesthetized patients and maintenance of the results from routine and nonroutine monitoring devices.

[38] Fiberoptic intubation is an effective technique for establishing airway access in patients with both anticipated and unanticipated difficult airways. The approach can facilitate airway management in a variety of clinical scenarios given proper patient preparation and technique, and has been utilized since the early 1960s. The technique can be utilized in awake, sedated, and anesthetized patients. Awake Fiberoptic Intubation (AFOI) uses a breathing tube placed in the breathing passage through the nose or the mouth when the patient is awake. When the patient is anesthetized during an operation, a breathing tube is placed in the windpipe to support breathing and maintain oxygenation.

airway requires the pre-surgical consideration of the use of awake fiberoptic intubation.

49. The standard of practice regarding providing anesthesia to a patient with a difficult airway requires the physician to consider the use of fiberoptic intubation if the patient experiences difficulty after the induction of anesthesia.

50. The standard of practice regarding providing anesthesia to a patient with a difficult airway requires that proper rescue airway equipment be available.

51. The standard of practice regarding providing anesthesia to a patient with a difficult airway requires that sufficient personnel with experience in anesthesia and airway management be available while the patient is undergoing surgery.

52. The standard of practice regarding providing anesthesia to a patient requires an appropriate airway assessment be done including the performance of an appropriate physical examination, which includes obtaining vital signs, height, weight, the documentation of an airway assessment, and a cardiopulmonary exam.

53. The standard of practice regarding providing anesthesia to a patient with a difficult airway for whom conventional intubation is not possible requires an appropriate airway assessment be done which includes taking steps to have additional airway equipment and sufficiently trained personnel readily available.

54. The standard of practice regarding providing anesthesia to a patient with a difficult airway for whom conventional intubation is not possible requires that the patient be encouraged to utilize local anesthesia.

55. The standard of practice regarding providing anesthesia to a patient with a history of hypertension, obesity, lower extremity edema, diuretic use and possible congestive heart failure is to have the patient's physician clear the patient for use of a general anesthetic.

56. The standard of practice regarding providing anesthesia to a patient is to correctly assign the ASA physical status during a pre-operative assessment.

57. The standard of practice regarding providing anesthesia to a patient requires the physician to clearly chart all medications administered to or considered for the patient.

58. The standard of practice regarding providing anesthesia to a patient requires the

physician to document the administration of premedication and prophylactic antibiotics.

59. The standard of practice regarding providing anesthesia to a patient is to document the presence of appropriate equipment to monitor the patient's oxygenation, ventilation, circulation and temperature.

60. The standard of practice regarding providing anesthesia to a patient is to document the use of appropriate equipment to monitor the patient's oxygenation, ventilation, circulation and temperature.

61. The standard of practice regarding providing anesthesia to a patient is to document the use of appropriate equipment to monitor the electrical activity of the patient's heart.

62. The standard of practice regarding providing anesthesia to a patient is to document the type, volume, or amount of time of any intravenous fluid given to the patient.

63. The standard of practice regarding providing anesthesia to a patient is to possess sufficient knowledge to recognize a possibly life threatening event.

64. The standard of practice regarding providing anesthesia to a patient is to possess sufficient knowledge to appropriately treat a possibly life threatening event.

65. The standard of practice regarding providing anesthesia to a patient requires the physician to be able to properly perform a lifesaving emergency procedure.

66. The standard of practice regarding providing anesthesia to a patient is to possess sufficient knowledge to prescribe the appropriate dosage of medication.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

(Bus. & Prof. Code, § 2234, subd. (b))

67. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that Respondent was grossly negligent in the care and treatment of patient A. The circumstances are as follows:

68. The facts and circumstances alleged in paragraphs 9 through 66 are incorporated here as if fully set forth.

69. Respondent was grossly negligent in his care and treatment of Patient A, taken

individually or collectively, or in any combination thereof, as follows:

(a) Respondent failed to follow the standard of practice when he failed to accurately and adequately record the patient's intraoperative anesthesia chart.

(b) Respondent failed to follow the standard of practice when he failed to accurately and adequately record the dose, time, and route of medications administered to the patient.

(c) Respondent failed to follow the standard of practice when he failed to utilize physiologic monitoring to accurately and adequately create the patient's intraoperative anesthesia chart.

(d) Respondent failed to follow the standard of practice when he failed to utilize physiologic monitoring to include accurate time based documentation of the patient's vital signs, medication and events to create an accurate explanation of what transpired during the patient's surgical procedure.

(e) Respondent failed to follow the standard of practice when he failed to ensure that the handwritten anesthesia chart records accurately reflected the patient's care.

(f) Respondent failed to follow the standard of practice when he failed to consider the use of fiberoptic intubation to deliver anesthesia to a patient with a difficult airway.

(g) Respondent failed to follow the standard of practice when he failed to consider the use of awake fiberoptic intubation to deliver anesthesia to a patient with a difficult airway.

(h) Respondent failed to follow the standard of practice when he failed to consider the use of fiberoptic intubation to a patient who experienced difficulty after the induction of anesthesia.

(i) Respondent failed to follow the standard of practice when he failed to ensure the availability of proper rescue airway equipment for a patient with a difficult airway.

(j) Respondent failed to follow the standard of practice when he failed to ensure that sufficient personnel with experience in anesthesia and airway management were available for a patient with a difficult airway who experienced difficulty after the induction of anesthesia while undergoing surgery.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

(Bus. & Prof. Code, § 2234, subd. (c))

70. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of Patient A. The circumstances are as follows:

71. The facts and circumstances alleged in paragraphs 9 through 66 are incorporated here as if fully set forth.

72. By the following conduct, taken individually or collectively, or in any combination thereof, Respondent was repeatedly negligent in his care and treatment of patient A:

(a) Respondent failed to follow the standard of practice when he failed to accurately and adequately record the patient's intraoperative anesthesia chart.

(b) Respondent failed to follow the standard of practice when he failed to accurately and adequately record the dose, time, and route of medications administered to the patient.

(c) Respondent failed to follow the standard of practice when he failed to utilize physiologic monitoring to accurately and adequately create the patient's intraoperative anesthesia chart.

(d) Respondent failed to follow the standard of practice when he failed to utilize physiologic monitoring to include accurate time based documentation of the patient's vital signs, medication and events to create an accurate explanation of what transpired during the patient's surgical procedure.

(e) Respondent failed to follow the standard of practice when he failed to ensure that the handwritten anesthesia chart records accurately reflected the patient's care.

(f) Respondent failed to follow the standard of practice when he failed to consider the use of fiberoptic intubation to deliver anesthesia to a patient with a difficult airway.

(g) Respondent failed to follow the standard of practice when he failed to consider the use of awake fiberoptic intubation to deliver anesthesia to a patient with a difficult airway.

(h) Respondent failed to follow the standard of practice when he failed to consider

the use of fiberoptic intubation to a patient who experienced difficulty after the induction of anesthesia.

(i) Respondent failed to follow the standard of practice when he failed to ensure the availability of proper rescue airway equipment for a patient with a difficult airway.

(j) Respondent failed to follow the standard of practice when he failed to ensure that sufficient personnel with experience in anesthesia and airway management were available for a patient with a difficult airway who experienced difficulty after the induction of anesthesia while undergoing surgery.

73. Respondent was negligent in his care and treatment of patient A when he failed to perform an appropriate airway assessment of the patient which included the performance of an appropriate physical examination, which includes obtaining vital signs, height, weight, the documentation of an airway assessment, and a cardiopulmonary exam.

74. Respondent was negligent in his care and treatment of patient A when he failed to assign the correct ASA physical status to the patient during a pre-operative assessment.

75. Respondent was negligent in his care and treatment of patient A when he failed to encourage the patient to utilize local anesthesia.

76. Respondent was negligent in his care and treatment of patient A when he failed to have patient A, a patient with a history of hypertension, obesity, lower extremity edema, diuretic use and possible congestive heart failure, obtain her physician's clearance prior to undergoing general anesthesia.

77. Respondent was negligent in his care and treatment of patient A when he failed to clearly chart all medications administered to or considered for the patient.

78. Respondent was negligent in his care and treatment of patient A when he failed to document the administration of premedication and prophylactic antibiotics to the patient.

79. Respondent was negligent in his care and treatment of patient A when he failed to document the presence of appropriate equipment to monitor the patient's oxygenation, ventilation, circulation and temperature.

80. Respondent was negligent in his care and treatment of patient A when he failed to

document the use of appropriate equipment to monitor the patient's oxygenation, ventilation, circulation and temperature.

81. Respondent was negligent in his care and treatment of patient A when he failed to document the presence of appropriate equipment to monitor the electrical activity of the patient's heart.

82. Respondent was negligent in his care and treatment of patient A when he failed to recognize a possibly life threatening event was occurring during patient A's surgery.

83. Respondent was negligent in his care and treatment of patient A when he failed to appropriately treat patient A when she experienced life threatening events during her surgery.

84. Respondent was negligent in his care and treatment of patient A when he failed to perform a life-saving emergency procedure on patient A who was undergoing life threatening events during her surgery.

85. Respondent was negligent in his care and treatment of patient A when he failed to possess sufficient knowledge to prescribe and/or administer the appropriate dosage of medication to patient A during her surgery.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

(Bus. & Prof. Code, § 2266)

86. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to keep adequate and accurate medical records relating to his care and treatment of patient A. The circumstances are as follows:

87. The facts and circumstances of the First Cause for Discipline are incorporated by reference as if set forth in full herein.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

(Bus. & Prof. Code, § 2234, subd. (d))

88. Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code in that he exhibited incompetence in his care and treatment of patient A. The

circumstances are as follows:

89. The facts and circumstances of the First and Second Causes for Discipline are incorporated by reference as if set forth in full herein.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

(Bus. & Prof. Code, § 2234)

90. Respondent is subject to disciplinary action under section 2234, subdivision (a) of the Code in that he engaged in unprofessional conduct in his care and treatment of patient A. The circumstances are as follows: The circumstances are as follows:

91. The facts and circumstances alleged in paragraphs 9 through 89, above, are incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 87499, issued to David Hwan Kim, M.D.;

2. Revoking, suspending or denying approval of David Hwan Kim, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering David Hwan Kim, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: March 14, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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